STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMILLION PLACE	449 MAIN ST ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure Survey. Survey dates: June 26, 2012 Facility number: 011970 Provider number: 011970 AIM number: N/A Survey Team: Tammy Alley, RN- TC Toni Maley, BSW Census bed type: Residential: 41 Total: 41 Census payor type: Other: 41 Total 41 Sample: 7 This state finding is cited in accordance with 410 IAC 16.2. Quality review completed on June 27, 2012 by Bev Faulkner, RN	R0000	Please accept this plan of correction for the survey of 6/26/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0216	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to evaluate residents ability to self administer medication and residents abilities to self perform medical services and activities of daily living for 2 of 7 residents reviewed for evaluations in a sample of 7 (Residents #57 and #1) Findings include: 1.) Resident #51's closed record was reviewed on 6/26/12 at 2:00 p.m. Resident #51 was admitted to the facility on 5/13/12. Resident #51's admission diagnoses included, but were not limited to, Alzheimer's disease, end stage liver disease and pulmonary fibrosis.	R0216	Corrective actions are not possible for Resident #51, being that he was discharged on June 2, 2012. Corrective actions for Resident #1 include completing a Self Administration of Medications Assessment by 7-26-12 to determine that he is able to safely administer pre-set medications. The facility administrator or her designee will complete a chart audit to determine if there are any other residents who require an assessment done to evaluate self administration of medications, ability to complete accuchecks independently, weigh themselves independently, provide catheter care independently, and/or self administer insulin. The director of nursing or her designee will complete any assessments or evaluations which need to be done. This will be completed by	07/26/2012

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	Resident #51 had a 5/17/12 "Mental Status Questionnaire" which indicated he had "moderately advanced impairment." The definition of this term was not included on the form. Resident #51 had a, 4/2/12, hospital progress note, from a hospital stay prior to admission, which indicated the resident had developed acute delirium with a recent illness associated with elevated ammonia levels. During his delirium the resident had reached a level of confusion where he swallowed his hearing aid. It was determined that the resident had not been taking his lactulose at home and this had contributed to his significantly elevated ammonia levels. Resident #51 had 5/2012 physician's admission orders, included but were not limited to, the following: a.) Accu-checks (fingerstick blood glucose testing) Two times daily and call the doctor if below 60 or above 400. b.) Daily weights and call doctor if patient gains 3 pounds in one day or 5 pounds in a week. c.) Routine catheter care. d.) Novolin N (insulin) inject 5 units		7-26-12. In the future, the nursing assessments will be completed upon admission or change of condition as needed. The Director of Nursing will be responsible to do this. Assessments will be reviewed along with the 6 month level of service evaluation that is completed. The administrator will complete an audit of the assessments and evaluations quarterly to assure compliance.	

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	subcutaneously twice daily. Resident #51 record indicated he self administered his medication after the medication was preset by home health services. Resident #51's clinical record lacked: a.) An assessment/evaluation for self administration of pre-set medications. b.) An assessment/evaluation of the resident's ability to complete accuchecks and notify the physician when indicated. c.) An assessment/evaluation of the resident's ability to weigh himself daily and inform the physician of 3 to 5 pound increases. d.) An assessment/evaluation of the resident's ability to provide catheter care as needed. e.) An assessment/evaluation of the resident's ability to self administer insulin. The clinical record also lacked any documentation regarding the resident successfully or unsuccessfully providing the above services for himself prior to 6/3/12. A 6/3/12, 10:30 p.m., Nursing Note, indicated the resident was very			

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	confused, had not taken any of his pre-set medications for the day and needed assistance emptying his urinary leg bag. The family transported the resident to the hospital that evening. A 6/5/12, 3:00 p.m., Nursing Note, indicated the resident's family had called and the resident once again had an elevated ammonia level and would now be a better candidate for skilled care at a long term care facility. During a 6/26/12, 3:00 p.m., interview the Director of Nursing (DoN) indicated Resident #51 had not had any assessment of his abilities to self-administer pre-set medications, inject insulin, perform accuchecks, complete daily weights, notify the physician when indicated, or provide self catheter care. 2.) Resident #1's record was reviewed 6/26/12 at 10:00 a.m. Resident #1's current diagnoses included, but were not limited to, a history of stroke with a right side deficit, diabetics and neuropathy. Resident #1's clinical record indicated he self administered his medication which had been preset by his wife. Resident #1's clinical record lacked an assessment/evaluation of the residents ability to safely self administer pre-set			

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	medications. During a 6/26/12, 3:00 p.m., interview, the Director of Nursing (DoN) indicated Resident #1 had not been assessed for his ability to safely self administer pre-set medications.			